WISCONSIN MEDICAID
PHARMACY SPECIAL HANDLING REQUEST
COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and dispensing physicians are required to retain a completed copy of the form.

Pharmacy providers are required to complete and sign the Pharmacy Special Handling Request when appropriate. Pharmacy providers submitting paper claims that require the Pharmacy Special Handling Request may submit the paper claim form with the Pharmacy Special Handling Request to the following address:

Wisconsin Medicaid
Pharmacy Special Handling Unit
Suite 20
6406 Bridge Rd
Madison WI 53784-0020

SECTION I — PROVIDER INFORMATION

Element 1 —Wisconsin Medicaid Provider Identification Number
Enter the provider's eight-digit Wisconsin Medicaid provider identification number.

Element 2 —Telephone Number — Pharmacy Provider
Enter the telephone number, including the area code, of the pharmacy provider.

SECTION II — REASON FOR REQUEST (Choose one.)

Element 3 — Emergency Supply Dispensed
Check the box to indicate that the pharmacy dispensed an emergency supply of up to 14 days per fill.

Element 4 — Original Claim Denied
Check the box to indicate that the original claim was denied and that the pharmacy provider is resubmitting the claim for reconsideration. Include the following information:

- Date of denial.
- Authorization / Internal Control Number.
- Explanation of Benefits (EOB) Number and / or National Council for Prescription Drug Program (NCPDP) Reject Code.
- Description of issue for reconsideration.

Element 5 — National Drug Code (NDC) not on Medicaid file
Check the box to indicate that the NDC submitted on the claim is not on the Medicaid drug file. Include the following information:

- National Drug Code.
- Description of NDC.

Element 6 — Pharmacy Consultant Review
Check the box to indicate that a pharmacy consultant review is being requested. Also check a box to indicate that the pharmacy provider is requesting a review for quantity limits exceeded or "other" reason. Include the following information when requesting an "other" review:

- Explanation of review needed.
- Supporting documentation such as Remittance and Status Report or manufacturer-reviewed and/or peer-reviewed medical literature.

When requesting a review for quantity limits exceeded for triptans, include the following information:

- Complete directions for use. ("As needed" or "PRN" are not sufficient.)
- The maximum triptan dose the prescriber has established by day, week, or month.
- The migraine prophylactic medication the recipient is taking. Specify the drug name, strength, directions for use and compliance.
- Indicate other abortive analgesic headache medications the recipient is taking. Specify the drug name, strength, quantity, directions for use and how frequently the medication is being filled.
- Indicate clinical information from the prescriber regarding the frequency of headaches and either why prophylactic treatment is not being used or why prophylactic treatment has been unsuccessful in reducing the headache frequency.

SECTION III — CERTIFICATION

Element 7 — Signature — Pharmacist or Dispensing Physician
The pharmacy provider or dispensing physician is required to complete and sign this form.

Element 8 — Date Signed
Enter the month, day, and year the Pharmacy Special Handling Request was signed (in MM/DD/YYYY format).